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TESTIMONY OF SHELDON TOUBMAN BEFORE THE HUMAN SERVICES COMMITTEE IN OPPOSITION TO PROPOSED CUTS TO THE HEALTH SAFETY NET IN HB 6367 AND IN SUPPORT OF CERTAIN REVISIONS THEREIN

Members of the Human Services Committee:

My name is Sheldon Toubman and I am an attorney with New Haven Legal Assistance Association. I am here to testify in opposition to the proposed cuts to Connecticut's essential medical assistance program for low income residents contained in the Governor's budget bill, HB 6367, as well as in support of one change in that bill designed to correct a problem created in the last deficit mitigation package and qualified support for another change, if revised to comply with another statute.

Support for Customized Wheelchairs Provision (Section 25)

First, I **support** the provision in Section 25 of HB 6367 which removes a problematic provision affecting access to customized wheelchairs which was passed in the deficit mitigation bill last December, Section 8 of HB 7001. The second sentence of this provision states that "Assessment of the need for a customized wheelchair may be performed by a vendor or nursing facility only if specifically requested by the department," indicating that advance permission is needed from DSS for a Medicaid recipient even to **request** prior authorization for a wheelchair through an equipment supplier. This would violate federal law in several regards. I am pleased to see that, after we wrote to the DSS Commissioner raising this serious concern, the administration has agreed to remove the offending sentence.

Unfortunately, many of the other provisions of HB 6367 are highly problematic, and will make severe cuts in the health safety net for low income individuals. These are discussed below.

Opposition to Elimination of Medicaid Coverage for Parents Over 133% of FPL (Section 21)

Most importantly, I am opposed to section 21 of HB 6367 which would end all Medicaid coverage for (non-pregnant) parents of minor children between 133 and 185% of the federal poverty level starting on January 1, 2014.

The proposal to end coverage for these parents flies in the face of the Governor's stated commitment to preserving the health safety net-- it would do just the opposite, throwing many of these vulnerable parents into the rolls of the uninsured.

The stated theory behind this draconian proposed cut is the assumption that these low income parents can instead buy private insurance on the new health insurance exchange intended to go into effect on January 1, 2014. That assumption defies logic because right now HUSKY A involves no cost sharing at all for all participants up to 185% of poverty. The health insurance plans on the exchange, by contrast, will be **unaffordable for individuals at these income levels**, with unaffordable premiums as well as high deductibles and copays—even *after* factoring in the subsidies from the federal government. Most of these parents will just go uninsured as a result.

As just one example, according to one of the available calculators estimating the approximate premium costs **with** the federal subsidies, the one run by the Kaiser Family Foundation (http://healthreform.kff.org/subsidycalculator.aspx), a 4-person family at 150% of the poverty level (annual income of about $35,300) will have to pay monthly premiums of about **$118**. The final premium may likely be somewhat less but this gives some idea of what these individuals will be facing, even with the federal subsidies.

But that is just to get into the gate. Then, according to the documents specifying the cost-sharing for the "Silver alternative" plan for individuals at 150 to 200% of poverty already adopted by Connecticut's Health Insurance Exchange (http://www.ct.gov/hix/lib/hix/Board_Approved_Standard_Plan_Designs_%2801242013%29.pdf), there is then:

1. A yearly deductible of **$500** before coverage (other than for drugs) kicks in
2. Many, many copays, including, among others:
    - **$15** per primary care doctor or mental health visit
    - **$30** per specialist visit
    - **$30** per x-ray
    - **$50** per MRI
    - **$100** per ER visit
    - **$250** per outpatient surgery
    - **$5** per generic drug
    - **$15** per preferred name brand drug
    - **$30** per non-preferred name brand drug
    - **50%** copays for all medical equipment and supplies
3. This does **not include** additional out of pocket payments for services currently covered by HUSKY A Medicaid but **not covered at all** under the standard plans on the exchange, like non-emergency medical transportation and dental services.

Keep in mind that in Connecticut we twice adopted and twice **repealed** very low drug copays of 50 cents and then $1.50 because even **these** copays restricted access. So

imagine what copays of $15, $30, $50 and even $250 will mean, even for those who can manage to pay the high premiums to get any coverage at all.

Here is a chart of the families on HUSKY A affected by this proposal (those between 133% and 185% of the federal poverty level):

Family Size	Annual Income
2	Between $20,628 and 28,694
3	Between $25,975 and 36,131
4	Between $31,322 and 43,568
5	Between $36,668 and 51,005
6	Between $42,015 and 58,442

While maybe going to an exchange for people at these income levels could make sense in **other** states, in CT, with its high cost of living for everything, it can't work. For these families, what going to the exchange instead of HUSKY ***really*** means is that the parents will lose all their health insurance because they can't afford it—and studies have shown that when parents lose their Medicaid coverage, the kids often drop off of Medicaid too, so the whole family becomes uninsured. This will undermine the whole point of "ObamaCare," which was to reduce the number of uninsured, not to increase those numbers.

Section 21 makes clear that these cuts begin January 1, 2014, with all new applicants denied Medicaid coverage if their incomes are over 133%. OPM has suggested that parents already on will have a year's grace period, until January 1, 2015, before they will be cut off, because of their eligibility for one year of Transitional Medical Assistance (TMA) under federal law. But this provides very little solace for three critical reasons:

1. TMA only helps parents with EARNED income- if a parent has only SSDI, alimony or some other non-wage income, they don't get TMA at all, so they would be cut off of Medicaid on January 1, 2014 with no grace period.

2. TMA under federal law is currently slated to end entirely on **December 31, 2013**, and, in light of the federal government's own budget problems, it is questionable whether it will be extended at all into 2014 or, if so, how limited the TMA benefits will be.

3. Even if TMA is extended by Congress, about 40,000 low income parents will by January 1, **2015** lose all of their Medicaid coverage, and it will be very difficult to reverse the cut once already made.

It has been suggested that these parents could get some kind of "wraparound" for the high cost-sharing, perhaps partly paid by the federal government. That solution isn't going to work either, for several reasons, including:

a. The indications are that, at best, the federal Medicaid agency, CMS, will partially reimburse a wraparound for **premiums** only, not co-pays and deductibles, and even that only where a pre-existing waiver is present in the state governing an expansion population. Most of the unaffordable cost-sharing is actually on the copay and deductible side. So it looks like the wraparound would be entirely state-funded, whereas HUSKY A parent coverage is reimbursed 50 cents on the dollar.

b. If CT did this, the wraparound would be precarious politically, with the next budget crisis likely resulting in a lowering or elimination of the wraparound (this is what happened with the disappearing Medicare Part D wraparound for dual eligible individuals).

c. Apart from the copays, the **covered benefits under exchange plans would be substantially less than under our Medicaid program** (e.g., no medical transportation, no dental coverage absent separate payment, much skimpier behavioral health services, a small number of PT, OT visits/year). The proposed wraparound won't help with these new, unaffordable expenses.

d. Parents would also be thrown back to mostly for-profit MCOs to get all their care with all the negatives that entails (we know that behavioral health will particularly suffer, but every benefit area is likely to see barriers to access beyond state-run Medicaid rules).

e. Having parents and kids in completely separate plans administered by different payers with different provider networks is not good in general, and also will make it less likely that a parent who signs up for insurance also gets it for his or her kids.

Need for Changes to Proposed Revisions regarding Behavioral Health Guidelines Statute (Section 31)

There are problems with existing Conn. Gen. Stat. § 17a-22p, referring to behavioral health guidelines used by the Behavioral Health Partnership. Right now, that statute provides that administrative services organizations shall authorize services, "based solely on guidelines established by the clinical management committee, established pursuant to section 17a-22k." This directly conflicts with the statute containing the broadly-applicable definition of medical necessity for the entire Medicaid program, including behavioral health services, Conn. Gen. Stat. §17b-259b, subsection (a). Section 17b-259b also provides that:

"(b) Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall ***not be the basis for a final determination of medical necessity***."

Section 31(c) of HB 6367 fixes this conflict **in part** by changing this language to say that the ASO shall authorize services "based solely on medical necessity, as defined in section 17b-259b." However, the proposed revision retains another contradictory provision and **adds** another one, both of which conflict with 17b-259b. Under section 31, the guidelines would be intended to "inform and guide the authorization decision." And this section would retain a statement that the only exception to the application of the guidelines is "the best interest of the member."

The intent behind 17b-259b, however, as drafted by the Medical Inefficiency Committee following extensive consultations with DSS, providers and advocates, was that these informal guidelines could be used expeditiously only to **grant** requests for prior authorization for services under Medicaid. If those guidelines were not met by a particular request, then, at that point, **only** the detailed medical necessity definition in 17b-259b(a), applicable to **all** medical services under Medicaid, could be used to make the final decision regarding presence or absence of medical necessity.

I therefor urge this Committee to accept the Governor's proposed revisions in Section 31 **except** that it should **remove** the problematic language: "An administrative services organization may make exceptions to the guidelines when requested by a member, or the member's legal guardian or service provider, and determined by the administrative services organization to be in the best interest of the member," and **replace** it with:

"Provided, however, that such guidelines may only be used as a basis for expeditiously approving a request for services. If a request for services does not meet such guidelines, the request may then be denied based solely on lack of satisfaction of section 17b-259b(a)."

Need for Increased Revenues

Finally, I would like to note that, rather than making these harmful cuts, we should be looking at the revenue side of the equation, such as making the state income tax more progressive and asking the well off in the state to pay marginal tax rates comparable to those paid in our neighboring states.

Thank you for the opportunity to speak with you today.